I'll just mention. You can do some nighttime reading of the full legislation. But Sections 932 and 933 are also under Subtitle C. And so, what those do, they mandate the expansion of integrative health, education, research, and clinical care.

So, Section 932 is actually a plan that was to be developed and provided for the VA Secretary on how we would go about doing that, which we've already completed. And I think that may have also been a read-ahead. And if you don't already have it, we can get that for you.

And then, also, Section 933 -- and Kavitha will get a little bit more into this on one of our later slides -- was the mandate for no fewer than 15 three-year pilot sites to expand complementary and integrative health. But, just as Dr. Gaudet was talking about, we can't really just plot integrative health into the medical center by itself. We really need the sort of systems approach of how to do that.

And so, those are our whole health system flagship sites, which we'll talk a little bit more about. And also, I think in Tab O in your binders is a whole list of the flagship sites, in case you're curious where those are.

So, the next few slides will go over education, research, complementary and integrative health approach, support, and then, also, the flagship sites.

We've talked a little bit today just about VA's sort of long traditional of education tailored for professional staff to meet the unique needs of our veteran population. And so, as VHA makes this effort towards a whole health systems approach for care, this paradigm shift really requires training and education for our staff, for veterans, for the integration of whole health and integrative health into care and treatment planning.

So, as such, while our office has been working on the different components of

whole health and that system, we also have an arm of our team that's solely focused on whole health education. And so, up on this slide I have some of our current and planned practices.

In fiscal year 2018, we had 58 national whole health education offerings which were delivered to our flagship sites. Some of those include: Whole Health in Your Practice, Whole Health in Your Life, Whole Health for Pain and Suffering, Eating for Whole Health, Whole Health Coaching, Whole Health Facilitated Groups, Taking Charge of My Life and Health, and also, a Whole Health Partner Course, so training of peers. So, there's a whole lot going on with this transformation. And I think in fiscal year '18 alone, we actually had trained about 3500 employees in whole health, which is pretty exciting.

Also, on top of that, with our flagship sites, we know that we can't just do all of this training nationally. So, we need folks who are locally at the medical centers.

We have identified two whole health flagship site education champions at each of our 18 flagship sites. They're there to really help train and deliver local trainings at each of our flagship sites.

So, that is the current practice. For our planned practice coming up in fiscal year '19, we have planned 119 national educational offerings. We also will have 46 offerings at our flagship sites. So, essentially, any of the flagship sites that requested to have these different trainings that I mentioned will be able to host those at those sites.

Some of our new whole health education initiatives, which we'll be able to get more information for you as they're being developed, but a Whole Health for Mental Health Course, which I think we're going to be trying to pilot two of those courses in fiscal year '19, in collaboration, of course, with the Office of Mental Health. And also, our Whole

Health Supervisors Course for the supervisors we have onsite for our whole health partners and facilitators.

And then, something else that Mr. Leinenkugel had mentioned earlier today, which is battlefield acupuncture. So, with our Whole Health for Pain and Suffering Courses, we're actually training clinicians to be able to provide battlefield acupuncture or regular acupuncture as a part, sort of an add-on to those trainings.

Our facility education champions are going to be delivering local courses using various curricula from our Whole Health 101, Whole Health in Your Life, and Whole Health in Your Practice.

And then, another exciting program that we're working on right now with some of our subject matter experts is VA CALM. And that's a mindfulness facilitator/instructor training that each of those flagship sites will be able to send a couple of folks to be

trained, so that they can, then, be leading mindfulness meditation at their sites.

And this next year, as I mentioned, we'll have 119 national educational offerings, which is very exciting. So, that's up from 71 previously, 39 in fiscal year '17, 26 offerings in fiscal year '16, and 21 in fiscal year '15.

Some of those will include, for clinical offerings of clinical staff, Whole Health in Your Practice; Whole Health for Pain and Suffering, which I mentioned; Whole Health for Mental Health, so those pilots, and then, also, Employee Whole Health Consultations. Some of our non-clinical offerings include: Whole Health Coaching, the Whole Health Facilitated Groups, and Whole Health Partner trainings.

In addition, we have a number of online resources as well. So, there is the option for employees to take trainings on their own online. We also have a Whole Health Library. And so, we can send you the link to

that. You can also just Google "VA Whole Health Library". This is open to the public. It's a whole bunch of different educational materials and courses, all the courses I mentioned. If you want to know more about it, a whole lot of information on there for you to take a look at.

We've also been developing and updating veteran-facing materials on there as well, so that they can go online and learn a little bit more.

And then, just continued ongoing training and mentoring of our VA education champions.

So, we were asked, in preparation for this briefing, to also talk a little bit about gaps and recommendations. It's always hard to even a take a look at yourself and try to identify gaps in the work that you're doing.

So, while we have a really strong whole health education program, a couple of things that we're noticing or getting requests

for from the different facilities is the need for more facility-level training for large employee populations. And so, VA medical centers have also asked for the train-the-trainer programs, so that they can not only offer education at a local level, but also train instructors at a local level as well.

And also, there's been a request for more integrative health approach provider training. So, like I mentioned with VFA, that's one example, but just taking a look into that in terms of additional types of trainings that we could provide.

So, some of the recommendations that we are looking at for our plan practice going into the future is, in fiscal year '20, to offer a train-the-trainer course for whole health facilitators and whole health partners. Really continue to work to make national whole health offerings flexible and customizable at the local level. Continue to help standardize whole health education as well to keep away

from slippage. And then, as I mentioned, enhancing integrative health trainings to include additional integrative health approaches beyond just our battlefield acupuncture. So, looking into the practicality of maybe mindfulness training, yoga training, tai chi training, things like that, inside of VA.

Then, with that, I'll hand it over to Kavitha to talk about research.

DR. REDDY: Thank you, Alison.

I might go to the next slide.

So, as Alison mentioned, CARA asked us to greatly expand the delivery of education, but also to look at research of complementary and integrative health, especially as it pertains to our patients with mental health illness, chronic pain, substance use disorder. And so, I really am excited to share with you some of the research that's happening now and some of the planned research going forward.

There's an $81 million collaborative

between DoD, VA, and NIH, actually, and multiple studies being done looking at CIH and pain management. Seven of those are being done within VA.

Additionally, our HSR&D is looking at how do we use these complementary and integrative approaches. If it's a part of a whole health system where we're really looking at patient engagement and activation, is that going to be far superior than just delivering acupuncture or just delivering chiropractic, where we're asking people to still come into the facility and be rather passive in their approaches? So, that is kicking off now.

We are looking at CHI for PTSD. Recently, in 2016, we had a state-of-the-art meeting where we looked at specifically non-pharmacologic approaches to pain, a very successful meeting, and those recommendations have recently been published as well in The Journal of Internal Medicine.

We have evidence-based synthesis

program reports on several CIH reports. These are quite useful in educating our providers and when and where to use these approaches in a personalized health plan with their patients. And we plan to be doing ones on hypnosis, biofeedback, and guided imagery. So, we'll have a really robust library of those reports, and we can share those with you at a future date as well.

And most recently, we brought together over 60 researchers for a two-day summit on CHI -- this was internal and external researchers -- and really were diving into CIH for pain, mental health, and well-being. We have several recommendations that came out of there, and we're working very closely with the Office of Research and Development, who has received all of these recommendations quite well. So, we're excited going forward to really partner further with Mental Health and the Office of Pain Management to look at some of those recommendations that came out of that

summit.

Additionally -- and I'm going to talk a little bit further about this when we actually talk about the flagship sites -- we have an entire evaluation strategy for the flagship sites where we are looking at outcomes. And I heard that come up quite a bit earlier today, and I'll share exactly what those outcomes are. But we are looking at well-being, engagement, activation, and their quality of life.

So, I mean, if asked to look for a gap, honestly, we feel really happy about the direction research is moving, and we will continue to further create stronger collaborations with Mental Health, so we can look at specifically CIH in mental health.

So, I'll hand it back to you to talk about CIH.

MS. WHITEHEAD: I could talk about this for a full day. So, I'll try to keep it brief. I'm very passionate about integrative

health.

And it's really a core component of our whole health system model, and I think we've come a really long way over the past -- even just since I've been with the office the past few years, but definitely since our office had started.

In terms of current practice, the group within our office that I work for is the Integrative Health Coordinating Center. And so, we were stood up within the office in 2014, based out of VA leadership desire for there really to be this coordinated effort around integrative health approaches. In talking to colleagues, I think early 2000s, maybe before that there had been bits and pieces of integrative health happening at different facilities, but really sort of a grassroots approach.

And for those of you who have worked in the healthcare setting outside of VA -- and with colleagues outside of VA, this is

something that is sort of new outside the VA as well. So, I think we've done a lot.

In fiscal year 2015, an internal VA survey showed that about 93 percent of the medical centers offered at least one type of integrative health approach, although that was not necessarily consistent across VA in terms of what was provided.

And then, more recently, a survey of approximately 1200 veterans on the use of, and interest in, complementary and integrative health showed that approximately 52 percent of those veterans had used any type of integrative health approach in the past year, which I thought was very excited. The top two reasons for use, which may not be a surprise, was pain and, then, also, stress reduction and relaxation. And some of the more frequently-used approaches, based on that survey, were massage, chiropractic care, mindfulness, and yoga.

The first bullet up there under

current practice, VHA Directive 1137, the Provision of Complementary and Integrative Health, so that's something that our office had been working on for quite a long time.

And also, around the same time, at the direction of the VA Under Secretary for Health, in 2016, we formed an advisory group that would help to evaluate and advise on which integrative health approaches, so evidence-based approaches, should be moved forward in the VHA and in what timeframe.

So, this group is made of subject matter experts from various program offices, including Mental Health, Pain Management, and others. And so, I'm mentioning that group because they're really an instrumental part of which of the integrative health approaches under Directive 1137 are considered part of the VA medical benefits package.

And so, approaches on our List 1, which I'll name in just a moment, must be provided through VA onsite via telehealth or in

the community as part of the medical benefits package. So, these integrative health approaches have to meet the definition of basic care as described in the medical benefits package, and must be in accordance with generally-accepted standards of medical practice, and as we heard earlier, to promote, preserve, and restore health.

So, this group of subject matter experts has really helped us. So, it's not just Kavitha and I sitting in the office deciding what integrative health approaches should be part of the medical benefits package, to make those decisions, and then, take that up to our National Leadership Committee at VA for signoff as well.

So, the current List 1 approaches include: acupuncture, biofeedback, clinical hypnosis, guided imagery, massage, meditation, tai chi, and yoga. So, you might think, oh, well, there's all these other approaches. Even in the legislation, it lists a whole long list

of different potential approaches for this group to look at.

And just one side note on that. Things like chiropractic care have been mandated at VA for a long time. So, we did not need to re-approve them. It doesn't mean that they're not happening or can't happen. They just did not need to be defined in the Complementary and Integrative Health Directive.

I know in August I think we're going to hear a lot more from physical medicine and rehab, recreation therapy, arts therapy, a lot of those other types of services, which are certainly a part of our whole health system. Again, they just did not need to be called out in our Integrative Health Directive because they've already been approved and are already being implemented across VA.

So, there's a lot of support and infrastructure that needs to be developed and happen to be able to implement these integrative health approaches, which are new

within the U.S. healthcare system in general, not just VA. So, a lot of what we've been doing currently or recently is building that business infrastructure to put into place a mechanism, for example, to be able to track these approaches.

I know you're all very interested in data. It's hard to collect data on procedures if the procedure codes and the U.S. healthcare system in general don't exist. So, we're developing sort of our workarounds using the CPT procedure codes that do exist and, then, also, some of our internal VA mechanisms, four-character codes, clinic stop codes, note titles, health factors, to be able to really take a good look at what we're doing related to integrative health and utilization.

At the same time, I had mentioned briefly an internal survey that was done in fiscal year 2015. We're working closely with VA researchers on a complementary and integrative health environmental scan, sort of

an internal survey looking at what integrative health approaches are being done across the board, by what types of providers. And I think that survey is actually closing the end of this month. So, hopefully, in the next few months we'll have some preliminary data that we can share on that as well.

Just a few other things that we've been working on related to integrative health approaches. One issue that we had seen was being able to hire integrative health providers. So, the development of qualification standards, minimum proficiencies. For example, in February, we just had published a qualification standard for a Licensed Acupuncturist. So, we can now hire acupuncturists at VA. Developing nationally-classified position descriptions for things like yoga instructors and tai chi instructors, so that those types of providers can also be hired at VA.

So, we have various subject matter

experts across the field helping with that. So, with the development of minimum proficiencies, position descriptions, qualifications, standards, et cetera.

And then, also, something else that we knew was very important was to really work with building a VISN infrastructure for whole health. So, we have a whole health network sponsors. We also have a group -- and this actually came out of the Opioid Safety Initiative -- but we have VISN-level complementary and integrative health points of contact on each of the VISN-level pain management committees. We, our office meets with them on a monthly basis. So, they're sort of part of that infrastructure and liaison to the field.

A couple of other things that we're working on, which I wasn't sure whether to put them in the current or planned practice, but expansion of integrative health through tele-whole health. So, we've heard a lot about

telehealth and telemedicine earlier today. We've been working a lot around that with the Office of Telehealth, the Office of Rural Health, and various subject matter experts.

To go on to our planned practice, really just continuing to grow each of our List 1 approaches due to supporting evidence that we've been being able to collect, and, also, developing new qualification standards as needed to help support the field. For example, we're working on a qualification standard for massage therapy right now. So, that will open up more of an availability for facilities to be able to hire Licensed Massage Therapists.

I had mentioned the potential training of integrative health approaches for current VA staff. So, our VA CALM training, the mindfulness training is one way that we're doing that.

And just really continuing to reinforce that integrative health should not be just a standalone service or program, but

really integrated into this whole health system of care.

And then, again, as I mentioned, the continued expansion of integrated health through tele-whole health; also, through the use of volunteers. So, one of the groups that I work closely with is Voluntary Services. We have 300,000-something VA employees, but I think there is also around 70,000, or some very large number, of volunteers. And we have a lot of folks who provide yoga or tai chi, things like that, that are really interested in providing this at VA on a volunteer basis, which is really exciting.

And then, also, something else is just the community partnerships, so partnering with groups in the community. For example, we have a national VA-YMCA MOU. You hear space is an issue. So, getting creative. Some of our sites will hold their groups, their peer groups, maybe their health coaching, something like that, can be held in a different space.

So, it's a lot of local MOAs are being developed between VA and YMCA, as an example, but there's other partnerships happening as well.

Then, again, looking a little bit at gaps and recommendations, one thing that we're working on, but that continues to be a gap, and something that we will continue to work on, I think, for a while, is just the consistent use of our new integrative health and whole health coding and tracking infrastructure. It's something that we're continuing to refine and revise, and it just takes time for the adoption of that.

And one of our recommendations going forward, I guess for ourselves, is really to align resources to support our VISNs, or our Veteran Integrated Service Networks, and local medical facilities to ensure the appropriate tracking of CIH approaches and, also, the appropriate delivery of approaches.

And now, I'll hand it over to

Kavitha, and she'll give you a little bit more of the details of the flagship sites.

DR. REDDY: Okay. Thanks, Alison.

I'm really happy to talk about this. I'm quite passionate about it. We are deploying a system that I think really speaks to what we're talking about here today. You cannot treat the mind without looking at the body. You can't treat the body without looking at the mind. And that is what whole health is.

In October of 2017, we launched these 18 flagship sites in each VISN. I work at one of those flagship sites in St. Louis, Missouri. So, I'm going to share some of our higher-level current and planned practice. And then, I just want to share some firsthand testimony to you as well.

Right now, we have those 18 sites launching, and we've had learning collaboratives following the Institute for Healthcare Improvement's Model for Collaborative Learning, in which we come

together for face-to-face meetings. We have action periods of process improvement and performance improvement. We have virtual meetings. But what it does is it gets us all on the same page for implementing, and then, we can evaluate that implementation consistently.

Again, I mentioned that we are looking at outcomes. We are tying those outcomes to the stage of implementation, so we can have a good look at what's actually happening.

Some of those outcomes we're looking at are sense of life meaning and purpose. We're using validated tools to measure this. Engagement in healthcare management, goal setting, perceived improvement in health and well-being, experience of pain, and healing relationships. I'm happy to share all of the tools we're actually using at a later time.

We really want to deploy this model over the next three years -- we're already deep into FY18, so the next two years after that --

touching at least 30 percent of unique veterans in each flagship hospital, so that we can really see, does this generate the outcomes we're looking for, does it generate a return on investment, and looking at these quality-of-life measures.

But the idea is that we are trying to transform the system where every veteran has a personal health plan and that looks at their social determinants of health. It looks at their meaning and purpose. It catches that suffering that Tracy was talking about.

I mean, I think all of us are recounting stories of patients that we've maybe missed those diagnoses in. I have my own personal ones, and they haunt you. And you also can maybe even think about your own family that's maybe struggled through those kinds of situations and the healthcare system maybe didn't answer to them.

So, in my mind, the flagships are really trying to look at how do we

comprehensively look at our patients. And then, that helps treat all these disorders. That helps treat all the illnesses that we're speaking of today.

Before I get to the gaps and risks, I just want to tell you about what's happening in real time. From this theory and this model, we're talking about what's actually happening at the flagships.

We are bringing in more veterans now because we're de-stigmatizing mental health. We're bringing them in saying, we want to focus on your well-being. We want to find out why you want to be healthy. And maybe the gentleman is telling me that he wants to hunt squirrels in the forest. I am in Missouri. So, just keep that in mind. Or the person that says he just wants to get down on the ground to work on his motorcycles. You find what it is that they want to work for and you start to uncover a lot of the backstory, right, things that they didn't want to share.

So, a few examples of patients already that we see we're helping. I had a young gentleman that came in that really did not trust the VA system at all. His issue was actually abdominal pain, lot of abdominal pain. CT scans negative. Scopes negative. Labs all fine.

Well, he came in finally to talk to me after talking to a primary care provider, a GI specialist, really going to different people. And he said, "I heard that whole health is happening here. I really want to look for a way to manage my abdominal pain."

Well, after we actually uncovered and went through this personal health inventory and uncovered his story, you find this long history of physical abuse from his father from a young age. Then, alcohol abuse, a sense of perfectionism that created a lot of trouble in the service. And you start to uncover mental health issues that were actually being seen by us as physical complaints.

And this is where it's missed, right? If he comes into an appointment, it's just seen as the physical complaint. You don't realize that he's struggling with depression and anxiety, a job he can't handle, a family that's overwhelming, and all the while he has to support that, right, as a young father.

So, my point being, there is a generation of folks that want to be seen this way. They want healthcare delivered this way. They want to look at how nutrition helps them. They want to look at non-pharmacologic approaches.

And most importantly, we take the stigma away. People experience anxiety and depression. We have to normalize that it's okay to talk about it.

That's one example. I have another young female who her story is about wanting to jump off the Jefferson Barracks Bridge every time she drives over it going over the Mississippi. And she somehow came to us and

started to work on her pain, her nutrition, her migraines. And slowly, we uncover a military sexual trauma that actually was feeding into a lot of her behavioral choices.

Now here we are a year later, I think you've actually heard from her in different panels, maybe some folks here. She says now she can go days without even thinking about that suicidal tendency. I mean, that's progress she hadn't had in years. Again, I'm just sharing a couple of examples of success we're already seeing.

And if you can't hear it in my voice, what that's also doing is helping the burnout of our employees. Because I was there and I have seen it all around me. You talk about same-day access with staffing shortages. You're seeing burnout. And when that compassion isn't there for patients because you're burned out, you've got a problem again. So, here we're talking about creating a system where employees are starting to feel incredible

about what they're doing now and fulfilled.

And so, I don't want to forget that there is a whole workforce in the whole health system that's built on peers. These are veterans delivering care to their fellow veterans in a group format. That could be peer support specialists as coaches. It could be peers that are volunteering to run groups and let their fellow veterans have space and time to talk about what's important to them. But, either way, this is another part of the workforce that we're creating to support this system.

And I think, finally, I just want to say community collaboration is a huge piece of this puzzle, too. We are actively in the YMCAs. We have a community churches reaching out to us. We have vet centers, ESOs. So, I think this is really about getting out into those communities and rebuilding that trust again.

If I could say one thing for the

group here about the recommendation, it is I can't say enough about how this feels like the way forward. And if that's the case, then we really have to align resources to develop this. And that needs to come from all levels of leadership, the highest levels to the program offices, to the facilities, to our direct supervisors.

So, that's the recommendation.

I'll turn it back over to you, Tracy.

DR. GAUDET: Yes. And in closing, before we get to your questions, I did want to draw your attention. These are just a few headlines. Have you ever done one of those exercises where it's like a visioning thing and they say, "Imagine, if you're really successful, like what would the headline be?" Hello? Like I am so blown away by these. These are real headlines, you guys.

Just so the people, if there is anyone on the phone, can follow this:

Columbia, Missouri, "More than medicine. Veterans hospital takes wellness approach to combat veterans' health problems."

Tomah -- go, Tomah, right, Jake? -- Tomah VA. "Whole health program gives options to veterans."

Tampa, Florida. "VA-YMCA team up to boost veterans' health."

Clarksburg, West Virginia. "Staff/patients embrace Whole Health Initiative at Clarksburg VA."

Iron Mountain, Michigan. "VA hospital/associated clinics offering holistic approach to care."

Insider VA. "VA uses whole health to prevent veteran suicide."

West LA. "Warrior pose: On the front lines of VA's wellness transformation."

Boston, Mass. "VA turns to alternative pain treatments amid opioid crisis."

And I also added that we were very

fortunate to have the opportunity recently to present an invited presentation to the Giving Pledge. And the participants of that group included Bill Gates, Warren Buffet, Richard Branson. This was the only healthcare presentation made to that group. Because they, too, understand how huge of a transformation this is, and that the public sector and the nation can learn from what the VA is doing in this. So, it's very exciting.

Our vision is that veterans committed their lives, their health, their well-being -- and I know many of you are veterans -- to mission success in defense of our country. And now, we want to help veterans be mission-ready for their lives, optimizing their health in service of what matters to them.

And when we think ourselves about how we know what success is, it's so amazing when veterans achieve outcomes that they never even envisioned possible. And it's not only

young, healthy veterans, it's all across the spectrum. It's as pertinent at the end of life as every place in between. And then, oh, guess what? By the way, clinical outcomes improve and costs decrease.

So, we are thrilled to be able to share with you the vision and the work that's happening in this.

And we'll turn it back to you, Jake, for questions and conversation.

CHAIR LEINENKUGEL: Well, Doctors, thank you so much.

The first time I met you, Tracy, and you did this presentation over a year ago, it was transformational for me. And then, I watched your approach and the team, whether it was Alison, Kavitha, and then, getting down to work with you in Tampa, it's changed me. So, I have a very biased view of what this is. And I refer to it, as I did earlier in the meeting, of sitting on a ham sandwich and starving to death.

But I am also one that advocated -- Tracy, you won't be cheering me now -- for mandating this.

(Laughter.)

DR. GAUDET: Oh. Well, I support you mandating it.

(Laughter.)

CHAIR LEINENKUGEL: You hit on something at your end that I know other commissioners are going to, hopefully, raise, but it does come down to resourcing and repurposing dollars and taking the senior leaders at VA to realize that ham sandwich while we are so-called starving to death. And I think that that has come previously. It was an "aha" moment for your entire group this past year.

I would say that you have the best momentum -- and I'm making a statement for the record on that right now -- because there is substance behind this. I mean, I could tell stories like Kavitha has just in my short

amount of time. So, I'm excited about this.

I'm going to defer to the rest of the commissioners for follow-up and let them use their time. But we will all, either together collectively or at least when we do our subgroups, we will all touch whole health and see it in practice, because I think that will be a mandatory statement that I would make to the commissioners, that they definitely see this in reality, live time, and in color.

DR. BEEMAN: First of all, I applaud all of your efforts. And I have a little story and, then, a comment to make. And please don't take the comment the wrong way, because I think there's an opportunity within the comment.

You have an awful lot going on. So, the first thing that I would ask is, is it too much? As I was listening, my mind was just spinning with all of the things you're trying to accomplish.

And one of the things that I've found out, and here's the story: when I was in

Lancaster, we had a Medicaid problem, as we do in most of the states. There wasn't enough money to go around. So, we decided to really focus on what we thought were the most intractable patients, and we picked 400 patients. We found that those 400 patients used 50 percent of the resources.

So, we hired a little extra staff. We created patient navigators that really were the go-to people. And we were able to reduce the emergency department admissions by well over 50 percent and hospital admissions close to 70 or 80 percent, and we saved all of this money, none of which came to us. It all went back to the state. Actually, it went to the managed care payers, which was kind of ironic.

The reason I mention that is that, in creating that extraordinary experience every time for those really difficult patients, we started to create the extraordinary experience and extrapolate that. And so, as I listen to you and say, you know, the primary care

physicians can't be that navigator. It's got to be somebody else in the continuum. And it sounds like you've got them, but maybe you need to codify more the kind of navigator that you're going to have.

And the other thing that I just wanted to share with you -- and this is not a criticism, but just a suggestion -- when I was running track in high school, my coach said, "You know what? Don't look at the person that's running next to you. Every time you do, Tom, you come in second and you watch his butt go over the finish line. Run your own race."

I hear a lot of us in VA comparing ourselves to the civilian. "We're better at this. We're better at that. We do this really well." No one cares. What you want to do is let's run our own race. Let's be so extraordinary that those 9 million veterans, the 3 million that don't come to us choose us because we're so extraordinary.

And so, there's an awful lot that

happens in this private side that's better than we can ever provide. And there's so much more here. Because I think that what we're doing is so noble, and we're ennobled by our patients and the special bond that we have with them, that we don't have to compare ourselves with them. Does that make sense?

So, it's not a criticism. It's like I hear it a lot, and I sit on a board with the local VA in Philadelphia, and they're always saying that. And I'm like, "But why? Because we don't need to say that." We need to be so incredibly good at what we do in our unique mission that we don't have to worry about what they're doing. Learn from them, but we don't have to compare ourselves to them.

Thank you.

DR. GAUDET: Well, and I appreciate those comments very much and agree with that. I'll just quickly respond to your first question about, are we trying to do too much? I'm an impatient person by nature, but on my

team we've coined the phrase "death by enthusiasm."

(Laughter.)

DR. GAUDET: But I will say, I was hired by the VA to stand up this effort in 2011. So, sometimes I look at it and go, "Man, it's taking so long." But not really, because it needs big system transformation.

And I will say, we were, I believe, very strategic about how we went about this. In other words, we helped defined a lot of external thought leaders and internal thought leaders. What is that future state? What are the qualities of that future state, et cetera?

But we didn't begin to know how to implement it, and we did not want to do that from the top-down because that fails every time. So, we really, over these years, have resourced innovation in the field, learned, observed, evolved the model, created education to advance what we know. And it has been a rather strategic evolution, to the point where

now we at least have a consistent model, which is done and we'll still learn and grow. But we know enough to say, these we believe are the core elements of this transformational approach, so that we can now look at this consistently.

And I worried about the VA workforce because I know how burned out everyone is, how low morale is. And I thought, oh, my gosh, is this going to be one more damned thing that they have to do and it's going to feel like a drain? And it's the opposite. It is restoring morale and passion and pride.

So, we do need to pay attention to that because we can do the death by enthusiasm thing. And I appreciate the observation. Thank you.

DR. JONAS: I have four questions, and these aren't all for you, but I want to get them out there because I think we need to hear from somebody about these.

Boy, Tom, I sure wish that we could

do that, and I hope you take his advice. Don't listen to me. Do exactly what he said.

And you're going to be compared. You're absolutely going to be compared. So, let's figure out how we're doing comparing and what the measuring stick is.

I know that you've built in and you've listed some of those things, but I just throw out a couple of questions about how would you create a good measuring stick for what we're trying to do here. And this is your evaluation component. You've done evidence-based mapping. We need to have evidence-based mapping that looks at what matters to the patient. Otherwise, we get the conflict between evidence-based medicine and person-centered care, veteran-centered care. And they often conflict. Okay.

So, we've got to figure out how to do that better. And so, that's a methodology issue. We need to figure out how to do that. Maybe your evidence bubbles, which VA has sort

of created, and is doing great, can be expanded and built upon, so you can truly get comparative effectiveness research.

I'll give you an example. Pain, pain medicine. Okay. They've said, okay, use non-pharmacological approaches. Okay. Well, how does that compare to using pharmacological approaches? We have no information about that in terms of cost, quality, outcome, et cetera. We have individual silos, but no comparative effectiveness component. Let's get the VA to do that. You're the only one that really has the data that can do that, in my opinion. Well, maybe not the only one; there's a few others that might be able to do it. So, that would be No. 1.

I would be interested to know if there are any civilian models out there that are doing something comparable and, if so, could we possibly gather some of them and actually look at that within this Commission? I mean, are there some systems out there that

are trying to shift the incentive model and the model of delivery on its head, so it's team care and it is a truly primary care-based model, not that primary care physicians are delivering it, but it's a primary care-based model? And that would be, I think, very helpful for some comparison component.

Finally, boy, we hope we learn about the electronic medical record because I've heard it's going to be rolled out in the next two years. I use the one in the DoD now. It's called AHLTA, but everybody in the system calls it "HAHLTA," okay, because it is so cumbersome. It's not friendly to anybody, the patient or the provider, et cetera.

And I know that some systems have had to actually redesign the electronic medical record because they could not find or execute on a commercial one that actually wasn't about payment in some way. And so, I hope we can get some information about that in those areas.

Then, finally, I just want to say

congratulations. We had some of the top leaders in the VA just before you at our closed meeting, and they all mentioned complementary and integrative medicine, every single one. So, it's like, okay, maybe we're getting there in those areas. So, you've been doing some good communication in those areas. So, congratulations on that.

DR. GAUDET: And if I could just add on the record, I am really grateful that you're interested in the electronic health record. We are not the experts, obviously, but I was briefed on that as a part of the Leadership Council last week. And we were told in that briefing that VA will have the opportunity to shift and define the content of that health record, which I think is paramount, because we can do all of this we want, and if it's not in the record -- so, I appreciate that the Commission is interested in that question because I think it would be very critical.

CHAIR LEINENKUGEL: Anybody else on

the Commission for any of the doctors at this point? Ladies, I want to thank you so much for your efforts.

There is one. Oh, thanks, Shira.

DR. MAGUEN: One more quickly. Sorry.

CHAIR LEINENKUGEL: Thank you.

DR. MAGUEN: Sorry to get in just under the wire.

But I wanted to just ask about, you know, one of the things that we've really been dealing with a lot at our medical center is people will request certain things and want massage therapy, et cetera, but there is no way to get that approved in the current system under certain -- I guess, when it's requested at certain parts of the medical center, it's not able to be approved. And so, I'm not sure. It seems like there's also a gap between these services being offered and available and the approval process for which veterans can actually get those services.

So, I would love to hear a little bit more about that and what you guys see for the future.

DR. REDDY: Okay. So, I'll start off by saying, absolutely. And I think when you look at these approaches in isolation, that's what happens when it's just an approach. "I just want chiropractic." "I just want massage therapy."

So, one of the things the flagship sites are really looking at is, how do we offer this as a part of a personal health plan with coaching, with motivational interviewing, so that this is one piece of the plan? I think there's a danger when it is just the approach.

But, second of all, we have looked at what literature does exist to create some national recommendations for frequency and duration of offering those approaches, so that there's at least a standard across the country for that. Of course, we're working with community care. We don't have a lot of updates

on that yet, on ways to be able to provide this in the communities when those resources don't exist.

And so, I'll start there. And if you want to add to that?

MS. WHITEHEAD: No, that was similar, yes, to what I was going to say. We're still kind of working on that. As Kavitha mentioned, just the duration and frequency guidance for massage, for acupuncture, we know we're going to have to develop this for some of those other approaches that I mentioned as well, as we begin to really start implementing them.

And we do have a national program lead for acupuncture, and we now have one for massage as well. Luckily, it's not just me having to come up with this guidance on my own. So, it's we're continuing to work on it, yes.

DR. MAGUEN: I will also say that what's been really neat is that some of our primary care doctors have been trained in

battlefield acupuncture. And so, we're actually seeing that they're able to get release time to do it onsite and have seen incredible results, too. So, I think that we're starting to kind of think about how can we work it into some of the staff that we already have there, which has been helpful, but we can't quite get that for whole health within every one of the domains.

CHAIR LEINENKUGEL: Thank you so much, Shira. Alison and Kavitha and Tracy, again, great to see all of you, and great, also, to see you making tremendous headway with whole health within the VA system. I personally believe it's the future. I think that you are leading in it right now, without really knowing who the true competitors are. But I think it's something that, when you see it in practice, when we all see it in practice and, then, talk to the veteran after the veteran has been exposed to what you have in your toolbox, and whether or not it's enough or

it's too much, you're figuring that out right now. And that's been just a delight to see. We, as commissioners, will be participating in the next 18 months to see more of it. But thank you all for your efforts.

(Applause.)

CHAIR LEINENKUGEL: At this time, let's take a 2- or 3-minute stretch.

(Whereupon, the above-entitled matter went off the record at 3:47 p.m. and resumed at 3:57 p.m.)

CHAIR LEINENKUGEL: Alicia, I'm going to begin, because I think that I want to start out with just a couple of the headlines here.

And thank you so much for coming before the Commission, this being our first public session. And it's very important for what you're going to present to us today, for us to get the context into what is taking place.

Dr. Alicia Carriquiry is a

distinguished professor of liberal arts and sciences and professor of statistics at Iowa State University. She also holds the president's chair in statistics and is director of the Center of Statistics and Applications in Forensics Evidence, an NIST Center of Excellence.

She was elected member of the National Academy of Medicine and a fellow of AAAS. She is also an elected member of the International Statistical Institute, a fellow of the American Statistical Association, so she is one heck of a statistician, is what Alicia is.

(Laughter.)

CHAIR LEINENKUGEL: But it's all about mathematics, bioinformatics. She's worked on animal genetics and also has done a lot of sponsored research through the Iowa State University.

Born in Uruguay, where she graduated as an engineer in 1982. After coming to the

United States, she received the M.S. in animal science from the University of Illinois, and also in statistics. Of course you did in statistics. And a Ph.D. in statistics and animal genetics in 1989. Both at Iowa State.

Welcome and thank you so much, Alicia.

DR. CARRIQUIRY: Thank you so much for having me. I am very pleased to tell you about the work we did in the context of this four-year-long study. The committee members and myself became best friends. Sixteen in-person meetings. This was a really important study. We were congressionally mandated to evaluate the Department of Veterans Affairs, and in particular the mental health services, focusing on the quality and quantity of the mental health services the veterans received, but also on the barriers and facilitators to access.

And the hope was that we would understand why some veterans do not use the

VA.

And among those that use the VA, what do they think about the services they receive?

So this is the formal statement of task. I've already said several of the things that are there. The focus was on veterans from OEF, OIF, and OND. And the way the committee was tasked to meet its goal was to collect a lot of different evidence.

So we not only reviewed the literature until the committee's -- until 2017, so I think we ended up at the end of 2017. We visited all 31 VISNs, several providers in each one of the VISNs. We obtained a lot of information from the VA itself, many of the surveys they use on their veterans, on their participants. And more importantly, we collected our own data.

So, the committee designed and filled in a survey that is representative of the veteran population of OEF, OIF, and OND. We ended up interviewing over 3,000 veterans.

As I said, this is a representative sample. So, the conclusions we -- or the results we draw from these particular veterans we interviewed can be extended to the population of veterans themselves.

Please stop me if you have any questions along the way.

This was the committee members. I had the honor of chairing this committee, but the rest of the members of the committee was a very distinguished mix of veterans, psychologists, psychiatrists, psychiatric nurses, sociologists, several statisticians, I should say. There was a lot of data that we were dealing with. And I think the diversity in the committee was very beneficial in terms of coming up with a report that I believe has a lot of very good information.

So, as I said before, the approach that we took was to collect all the available information. So, survey of veterans, site visits, information from -- and during the site

visits, I should say, we talked to as many people as possible. We talked to veterans that used the VA. We talked to veterans that didn't use the VA. We talked to family members. We talked to community providers. We talked to VA providers at all levels. And so I think those visits were pretty intense and we got information from all sides.

Yes?

MR. ROSE: Just a quick question. How did you reach the people that were not seeing the VA?

DR. CARRIQUIRY: That is a very good question. And that's a very difficult population to reach. So, we relied a whole lot on VSOs and other community organizations. We did a bit of a -- we contacted many of those organizations ahead of time in each of the places we were going to visit and requested that they communicate with veterans that they know are not using the VA so that we would have access to them. And it was hard.

And we, of course, managed to interview many more users of the VA than non-users of the VA, but we did have a pretty healthy sample of non-users. So, that was the hard part.

We obtained a lot of information from the VA itself. So, many of the surveys and other information that the committee requested. And, of course, we did a very thorough review of the literature.

All this information was synthesized. Combined where possible. We tried to look at each of the topics in which we were focusing and bring in all the information we had.

So, if you look at the report, for each topic we have what the literature says, what the data suggests, what the VA thinks is happening, and what the site visits revealed. Site visits, of course, are more anecdotal, but some of this anecdotal information is really interesting.

We developed some findings and conclusions and have a list of recommendations. I don't know how much you know about the National Academy of Sciences process, but these reports are called consensus reports. So, once the report is finalized, the entire committee needs to sign off on the report.

That's a very powerful statement. It means that this very diverse group of professionals agrees with the findings and the recommendations.

And then the report goes out for a thorough review. So, in this particular case, it went out to something like 16 external reviewers from all areas. The committee doesn't know who the reviewers are, of course. And these reviewers came back with about 90 pages of comments and request for changes and so on. We tried to be responsive to the reviewer's comments. And what you see there is the final version of that report.

So, what are some of the key

findings? I think we had some interesting findings.

Number one is that there is a substantial unmet need -- but I think that's not news -- for mental health services among the OEF, OIF, and OND population. Interestingly, about half of the veterans that were surveyed by the committee who may have a need for mental care services do not use the VA or any other mental health provider. So, neither the VA nor the private sector. And that's because most of them are not even aware that they have a mental health need.

So we found that among -- you know, those are people that are hard to reach, right? They don't think they need help. And therefore, they're not going to be seeking help. And so that was a very interesting finding.

The other finding was that there's several barriers for access. But the number one, by a mile and a half, barrier to access is

the clumsy transition between DoD care and VA care. The transition of veterans from the care they received while on active duty to, you know, entering into the VA system is a huge barrier.

The process is burdensome. The veterans get lost in the shuffle. You know, they receive information from the VA before they separate, but they get this information when they're about to separate. They don't want to hear anything. They just want to get out of there.

And so this information on how to access care at the VA is probably not provided at the best of times. And so many of the veterans that do not use the VA system don't do so because they simply don't know how to navigate it.

And so that's -- I think it's going to be reflected back in our recommendations. That was our number one recommendation, to try and, you know, sort of marry those two systems

so that there's a seamless transition between DoD care to VA care.

One of the other things that we found that was kind of interesting is that veterans that have support from family members, from friends, tend to do much better than veterans that do not have such support.

So, reaching these, you know, reaching the larger community around the veterans is a good way to ensure that veterans will not only seek services but also stick with the services. So that was one of the big facilitators that we found.

And some of the barriers, aside from the fact that navigating the VA initially is very difficult, are things such as, you know, things that are as mundane as transportation challenges, employment concerns, stigma, the fear of stigma.

For example, we find that many of the veterans that live in rural areas, for example, sometimes have to dedicate an entire

day to come for a visit of the VA. Two hours in a bus from somewhere. Then the visit. Then two hours back in the bus. This is a real deterrent to seek care.

Employment concerns are pretty real. Many of the veterans end up employed in the private sector in security sectors, police. And being diagnosed with a mental health issue for them may mean, or they think it may mean, employment issues, problems.

The ability to own and carry guns is a big concern of veterans. Many veterans do not seek care because they think that might lead to a loss of a permit to carry and own guns, also to loss of contact with or custody of their children, concerns about loss of medical, disability benefits. There's many issues that have very little to do with the quality of care that the VA provides, and a lot to do with the environment in which these veterans operate.

This said, once a veteran is in the

VA system, in general the reports are very positive. So, veterans have a very good -- well, let me -- many veterans report a very good experience with the VA mental health services. They wish they could get more of it and they could get it faster. But once they get it, they really like it.

They report the fact that there's a wide variety of services they can access. They trust that their records are going to be private and confidential. They like the fact that it's possible to integrate primary healthcare with mental healthcare at the VA, something that is very difficult to do in the private sector.

There's exceptions, of course. But they are satisfied with the staff's skill and expertise, and oftentimes with the services they get from staff like, you know, schedulers and these kinds of people.

There's many complaints, too, of course. But, overall, that's what the data

suggested.

So some of the other key findings that we report on is that even though many veterans do receive very high quality mental healthcare from the VA, there's a lot of unevenness in the system.

So, not all VA providers are the same quality. There's some underperforming -- there's underperforming facilities within the VA system.

Which is not surprising. Most oftentimes due to staffing challenges, physical infrastructure that in some locations is really subpar.

And, you know, all of this leads to challenges in providing timely care to the veterans, and, in particular, on staying faithful to evidence-based services that require, for example, repeated visits at certain intervals and so on.

Like it was noted before, there's burnout and job-related stress among VA staff at all levels. Medical staff, administrative

staff. And that contributes to high turn ver. And part of the issue is that many of these individuals are carrying out tasks that are simply not what they should be doing. So you find clinicians doing a lot of administration. You find administrators doing things that, you know, they were not expecting they would have to do.

We found, one of our big conclusions in the committee was that the care that veterans received in the VA is generally at least comparable, but typically superior in quality to the mental healthcare that is provided in the public sector and in other non-VA public sectors.

And in fact, the VA has some foci of absolute excellence in the area of mental healthcare. There is really -- this is the largest mental healthcare provider in probably the world; certainly, in the United States.

It has enormous advantages in that the VA, of course, is also a teaching

institution. So you have the research paired with clinical practice. There is a quick transition from research to practice in many of the different types of care that the veterans receive.

There's, like we said before, this ability to integrate primary healthcare with mental healthcare that is very difficult to do in many other places. And of course there's the culture. One of the things that veterans very much appreciate is the fact that in the VA they find themselves, you know, among their tribe. So, there's other veterans. There's a lot of providers that are themselves veterans. And this is something that veterans really appreciate a whole lot.

MR. ROSE: One more quick. Back to burnout. Did caseload play into that?

DR. CARRIQUIRY: Yes. And that's the other thing that -- yes, caseload plays into that. Everything plays into that.

The fact that, for example, a

clinician doesn't have the facilities to carry out small group sessions. Or doesn't have, you know, the staff to take good records and has to be typing himself or herself while listening to a patient. All of those things contribute to burnout.

There's a lot of unevenness in the system. There's some providers in the VA, within the VA system that are doing just fantastically well. And there's other providers that are underperforming, for many reasons. Some of it has to do with staffing.

There's a lot of -- there has been a lot of attempts to coordinate activities with other community providers. And there's some formal programs -- for example, the Veterans Choice Programs. This is all good. The committee was all in favor of the VA coordinating services with community providers. But, of course, there's this issue that all community providers are not within the VA.

So, the controls, the quality

control that goes on for VA providers, it doesn't really go on for providers outside of the VA. So there's an issue about making sure that the quality of care that veterans receive outside of the VA, but with the blessing of the VA, if you will, is really the type of care that the veterans would have received in the VA.

So, high quality, evidence-based, patient-centered. Though there's this issue with, you know, those things do not necessarily complement each other.

So it's very important to -- so, one of the findings, of course, a conclusion is that there's a lot of opportunities to improve the mental healthcare that's provided by the VA. And perhaps one of the most important recommendations is ensuring consistency and predictability of high quality care across the entire system. And then I have some ideas on how that might be -- I don't, my committee has some ideas on how that might be carried out.

So the number one recommendation was to encourage the VA to set a very lofty goal of becoming a high reliability provider of high quality mental health services throughout the entire system within three to five years.

In the report, there's many different parts to this one recommendation, but it has to do with removing as many barriers to access as possible; soliciting information systemwide from patients, from providers, from the community, from the staff, about what needs to be done; evaluating service improvement programs such as MyVA. How is that working?

Addressing workforce issues. In particular -- and there's another recommendation about that -- in particular, trying to make the hiring system more agile. It's very difficult sometimes to hire people into the VA.

Continue integrating the services of non-mental healthcare providers with the VA healthcare providers. Again, making sure that

quality is maintained even outside of the VA system.

Facility and infrastructure needs, things such as parking spaces is important.

The need, for example, to have, sometimes, separated facilities for men and women. Women sometimes feel threatened if they have to be in the same waiting room as men. So this kind of infrastructure improvements are important.

I'll say some more about this, but the use of virtual care technologies, including telehealth and internet-based technologies. This is a very promising activity and is likely to help resolve several problems. And I'll talk a little bit about that in a minute.

Deployment and use of evidence practices. Increasing the use of AVPs through efficient and scalable training procedures. And, of course, identifying and addressing research gaps and other priorities.

The VA needs to eliminate barriers

to accessing mental healthcare. Some of those are going to be easy to do. Some of those are going to be very difficult to do.

Engaging the family or the circle of friends of VAs into the care that the veterans receive is clearly something that's beneficial. There's some barriers, like, for example, distance that can be addressed using things such as telemedicine. Staffing problems can also be addressed, perhaps, using virtual care, telemedicine. So, there's many of those barriers that need to be addressed before veterans will participate more fully in the VA.

I talked about this already. So, examine how the facilities interface with community resources. And there's some very many good examples. But the best practices and the quality control needs to be extended to non-VA providers that participate in these agreements.

One should ensure that the diverse patient population receives accessible, high

quality, integrated mental healthcare services. The needs, for example, of women veterans, minority veterans, LGBT veterans, are not the same as the needs for, you know, a straight male veteran.

This, of course, is the first time when a very large proportion of women veterans were deployed. These were mothers of young children. Sometimes you had both mother and father deployed. These stresses are really -- these are new stresses that the veteran population is under, and those stresses require a specific type of care.

The homeless veteran population is another population that sometimes is underserved. So there's a need to -- of course, most of the homeless is Vietnam-era veterans, not necessarily the OIF, OEF, and OND veterans. But, nonetheless, this is a population that is underserved, and agreements such as those that exist between VA and the housing authority to find housing for these

veterans is really important.

As the VA gets additional staff, it would be great if the VA keeps in mind that veterans much prefer to be cared for by fellow veterans who understand the military culture, understand where they've been and where they're coming from. So maintaining a diversity in the provider population is also very important for the veterans.

Hiring is an issue in the VA at some levels. So, one of the recommendations, sometimes the hiring process is very long and convoluted and by the time an offer is made to a professional, the professional has already been working, you know, for six months somewhere else. And so making the system more agile is important.

And so one recommendation is to explore whether every mental healthcare worker, at all levels, can be brought under this Title 38 that alleviates -- that makes the hiring process much more flexible and easy to get

through.

The facilities, again, we talked about the physical plant and the human resources. There's a need for alignment. I'm not saying that more resources are not needed, but the resources that do exist need to be better aligned with the type of outcome the VA wishes to achieve.

And there's a strong need to lessen administrative and clerical burden on clinicians. Improve the quality of fidelity treatment. This has to do with -- you know, whether you can provide the treatment as you should depends on not only staffing but also the availability of facilities. And, of course, more adherence to clinical practice guidelines.

One of the things that the VA is extraordinarily good at is developing new technology and implementing new technology. So the VA should leverage its existing health technology infrastructure and top of the line

expertise in telehealth and virtual care -- there's nobody better than the VA in terms of virtual care and telehealth -- to achieve many things.

Number one, by scaling up the amount of care that is provided at a distance, it would be possible, for example, to alleviate transportation problems for veterans that live in rural areas. It might be possible to alleviate some staffing shortages in other areas. A clinician that is providing care at a distance doesn't have to be sitting in the same VISN as the patient that's receiving that care.

So there's a possibility of, you know, making this expertise more uniform through the entire system. Telehealth is also very beneficial for those veterans that really feel uncomfortable in crowed situations, that do not want to visit crowed waiting areas. So there's a lot of promise in terms of expanding the use of telehealth, I think.

And, finally, I think this is the

last recommendation. The VA should take this opportunity to lead the nation in terms of advancing quality management in mental healthcare.

So, the VA collects a lot of information. So, there's many, many, many, things that are measured in the VA, but most of those have to do with process. So the VA has a lot of process indicators, not so many outcome indicators.

And so one of the recommendations is that the VA seriously think about developing a robust portfolio of mental healthcare performance measures, outcome indicators that can be rolled out, can be implemented and maintained.

And I am not in the business of recommending, you know, bringing business to the National Academies, but I think that a perfect consensus study would be, what are affective outcome indicators? How do you measure what you want to measure? How do you

track? And furthermore, how do you put them into practice to improve the services that the veterans get?

So, I just wanted to put that bug in your ear. I think this is a very important topic that deserves some attention. So that's all I had to say.

CHAIR LEINENKUGEL: That was great. Thanks, Alicia. I've got a number of things. But I'll defer while some others ask a couple of questions.

DR. CARRIQUIRY: Sorry, before we do that, I'm at your disposal. So if you have any questions as you do your work -- and so is the committee. Any of the members of the committee would be happy to talk with you.

CHAIR LEINENKUGEL: No one wants to go before me? Really? Okay. I'll go.

I get the subset of what I call "the long war" participants, where they're at 17 years now from the War on Terror. Or I like to refer to it as really 27 years, since 1991.

So, it's become a long war. I get that subset. But I also would go back to the VA and to the people on the study and say, what does that group really represent within the VA ecosystem of veterans currently using the VA? And I wonder if that was ever addressed.

DR. CARRIQUIRY: In terms of proportions?

CHAIR LEINENKUGEL: Proportions.

DR. CARRIQUIRY: It's definitely not the majority of the veterans that use the VA. So the lion's share of VA users is Vietnam veterans, or Vietnam-era veterans, definitely.

CHAIR LEINENKUGEL: And so, clarify for us why this group was so important for reviewing the mental health of the VA system at that time.

DR. CARRIQUIRY: I think this group was very important for several reasons. Number one, like you say, this is the longest conflict that the U.S. has been involved in. This was the first time that women were deployed in

large numbers. The all-volunteer Army, what happened was that these poor guys were deployed multiple times for very long periods.

And so there were very specific -- you know, there were stressors that were present for this particular generation of veterans that may not have been present for others. And the demand for mental health services just exploded. And so, you know, the VA found itself with an additional two million people seeking mental healthcare coming back from these wars. And so I think that's part of the trigger.

CHAIR LEINENKUGEL: I wanted to hear you clarify that so we all have that distinct understanding as to why that subset group of veterans was used.

There's a couple of things that were on the recommendations that I think we, as commissioners, will take a look at deeply. And a couple that jumped out at me personally were, when you say veterans like to be cared by

veterans, there's no question about that.

You hear that anecdotally. And then when you're out in a center and you see a veteran who served with another veteran, whether they're providing care or just a peer counseling session, is dynamite. It's money in the bank.

And you and your team brought that up. There are things that we're going to talk about as a Commission that should be outcomes of this.

So when did this complete? When did this study complete? And when did the recommendations go to the VA?

DR. CARRIQUIRY: This study completed in December of last year. And the report was published in January of this year. So, I believe towards the end of January. I'm almost sure it was towards the end of January.

CHAIR LEINENKUGEL: Yeah. And just from my recollection, I've heard bits and pieces of this, but not to the clarity that you

just presented in a very clear, short amount of time.

So that's interesting that eight months have gone by. And I would surmise that somebody has this, whether it's one of the doctors that was going to report to us next month, or has already reported, that they're well aware of it. And Drew, as an adviser, sitting in the back room, just came in. And I know that you are aware of this as well. Correct, Drew?

MR. TROJANOWSKI: One hundred percent.

DR. CARRIQUIRY: Let me say, in the VA's defense, this report came out when there was a lot of turnover in the VA. You know, leadership changes and lots of things going on. So it may not have received -- it was probably not --

CHAIR LEINENKUGEL: That's more than fair, Alicia. Two points for the commissioners. Because it's going to come up

before us. Again, it's another ham sandwich that we're sitting on and we're starving to death. They're ICTs. And if you're in the military, you know what an ICT is. It's that medic, corpsman, doc, it's that individual that went down to San Antonio -- I believe that's where they're all trained, if I remember -- and got distinct training, trauma training.

I mean, these men and women can perform battlefield tracheotomies and do a whole bunch of stuff. Yet it's hard as heck for them to get into the VA. In most cases that door is slammed. So, that needs to come to this. Because you know how many are getting out every year? Over 10,500 are being separated from the military every year.

Do you know how many we have in our ICT program that's been going on for over five years? Seventy-three. And we have what's called a clinician shortage in the VA. So, I bring that up because you brought it up with your other recommendation on hiring, which was

Title 38. And that actually is part of the solution. There's no question.

So, I only bring that up for the sense of urgency from this Commission going forward, that we have a couple of big things just on day one that I think we can further explore and make recommendations on as well.

Tom, do you have something?

DR. BEEMAN: I have a question. And I know it's not directly relevant to your study. But I'm curious if you've heard of any studies about resiliency training in the DoD and whether or not any of the services employ it and are effective, then, in mitigating some of the mental health requirements when they get out.

And then secondly, just anecdotally, I remember in particular, I won't -- I'll cite the service I thought did a great job. The Marine Corps, when we were treating PTSD and TBI patients, were part of the care process. So, the sergeant and the platoon lieutenant